Managed Risk Medical Insurance Board
May 29, 2013, Public Session

Board Members Present:	Clifford Allenby, Chairperson Richard Figueroa Ellen Wu
Ex Officio Members Present:	Jack Campana, Chairman of the Healthy Families Advisory Panel Robert Ducay, Designee for California Health and Human Services Agency Gary Baldwin, Designee for the Secretary of the Business, Housing & Transportation Agency
Staff Present:	Janette Casillas, Executive Director Terresa Krum, Chief Deputy Director Laura Rosenthal, Chief Counsel, Legal Tony Lee, Deputy Director, Administration Ernesto Sanchez, Deputy Director, Eligibility, Enrollment & Marketing Jeanie Esajian, Deputy Director, Legislative & External Affairs Ellen Badley, Deputy Director, Benefits & Quality Monitoring Jenny Phillips, Staff Counsel, Legal Rebecca Dietzen, Senior Staff Counsel, Legal Carmen Fisher, Staff Services Analyst, Legal Amanda Evans, Manager, Administration Loressa Hon, Manager, Administration Jordan Espey, Manager, Legislative & External Affairs Larry Lucero, Manager, Eligibility, Enrollment & Marketing Lilia Coleman, Manager, Benefits & Quality Monitoring Tony Jackson, RPS1, Benefits & Quality Monitoring Juanita Vaca, RAII, Benefits & Quality Monitoring Alexa Malik, Benefits & Quality Monitoring Maria Angel, Executive Assistant to the Board and the Executive Director Elva Sutton, Board Assistant
Also Present:	René Mollow, Deputy Director, Health Care Benefits & Eligibility, California Department of Health Care Services
Public Comment:	Elizabeth Abbott, Health Access

Chairman Allenby called the meeting to order at 10:00 a.m. The Managed Risk Medical Insurance Board went into Executive Session and resumed public session at 11:00 a.m.

Chairman Allenby introduced Gary Baldwin, the new ex-officio member from the Department of Managed Health Care [designee of the Secretary of Business, Transportation and Housing].

REVIEW AND APPROVAL OF APRIL 17, 2013 PUBLIC SESSION

The minutes of the April 17, 2013 public session were approved as submitted.

The April 17, 2013, Public Session Minutes are located at: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_3_Public_Minutes_4-17-13_Final.pdf

STATE BUDGET UPDATE

Update on the Healthy Families 2012-13 Shortfall

Tony Lee reported on Agenda Item 4.a, Update on the Healthy Families Program 2012-13 budget shortfall. In Fiscal Year 2012-13, the budget assumed that the Managed Care Organization tax extension would begin July 2012. The Legislature did not act to extend the MCO tax, leaving MRMIB with insufficient funds to pay HFP invoices.

MRMIB staff has contacted all HFP plans and the administrative vendor to advise them that payments will be delayed while MRMIB works with the Administration to seek a remedy. The Administration is seeking to extend the MCO tax to fund HFP in the May Revise budget. The May Revise budget proposal for MRMIB includes $128 million from an extended MCO tax, which would allow MRMIB to draw down $238 million in federal matching funds for a total of $366 million in funding for HFP.

The MCO tax extension proposal also includes General Fund loan authority that would allow MRMIB to process capitation payments to plans, as well as administrative vendor invoices for the services rendered for December 2012 through May 2013; these invoices can be processed immediately after trailer bill language is enacted. As of today, MRMIB owes plan partners $271 million in capitation payments for December 2012 through May 2013, and owes the administrative vendor $10.02 million to the administrative vendor for January through May 2013.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

May Revision

Loressa Hon reported on Agenda Item 4.b, the Governor's 2013-14 May Revision. The Governor's May revision for Fiscal Year 2013-14 provides a total of $242 million for all MRMIB programs. The budget does not include Pre-Existing

Condition Insurance Plan funding, since California PCIP subscribers will transition subscribers to the federally-run PCIP on July 1, 2013. At this time, it is not clear what PCIP funding will remain with MRMIB.

Ms. Hon stated that the budget continues to propose the transition of HFP children to Medi-Cal that began on January 1, 2013. Control language in the budget allows the transfer of funds between the Department of Health Care Services and MRMIB budgets to ensure adequate funding.

The Major Risk Medical Insurance Program budget includes $31.18 million to cover MRMIP and GIP [Guaranteed Issue Pilot Program] costs for the budget year.

Ms. Hon explained that the Administration has developed a proposed timeline for transition of MRMIB's remaining programs. The timeline proposes that Access for Infants and Mothers (AIM)-linked infants transition to DHCS on October 1, 2013 and that MRMIB and DHCS draft a Title XXI State Plan Amendment to establish the Children's Health Insurance Program under DHCS for AIM-linked infants. Under the Administration's proposal, MRMIB would continue to administer AIM for mothers until June 30, 2014. On July 1, 2014, AIM would transition to DHCS.

The Affordable Care Act requires that all CHIP eligibility that existed prior to its enactment continue; failure to do so constitutes a violation of the ACA's CHIP maintenance of effort provision. Therefore, California is required to operate Children's Health Initiative Matching Fund program in its present three counties. Under the Administration's proposal MRMIB would continue to administer CHIM until June 30, 2014. On July 1, 2014, the responsibility for CHIM would transition to DHCS.

Ms. Hon explained that the Administration is not proposing to eliminate MRMIP at this time, and the program will remain with MRMIB, where it will be operated as it is currently. Under the Administration's proposal, on July 1, 2014, the responsibility for MRMIP would transition to DHCS.

Effective July 1, 2103, the state will no longer operate PCIP on behalf of the federal government. Subscribers in the state-run PCIP will transition to the federally-run PCIP on that date.

The Administration's timeline proposes that the Board continue to operate through fiscal year 2013-14, to oversee the remaining HFP transition of Phase 3 and 4, the AIM-linked infant program until October 1, and the AIM, CHIM and MRMIP programs, as well as the close-out of the state-run PCIP. The Administration proposal anticipates that the Board will be dissolved effective July 1, 2014, with remaining program activities transitioning to DHCS.

Finally, Ms. Hon stated that MRMIB will work to assist PCIP staff to find employment at Covered California. Staff members who remain at MRMIB through the 2013-2014 close-out of MRMIB's other programs would be transitioned to DHCS, effective July 1, 2014.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The Governor's May Revision Overview is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_item_4b_Final_Governor_Budget_Review_MRMIB_2013-14.pdf

Budget Hearings

Mr. Lee reported on Agenda Item 4.c, Budget Hearings. Staff attended the Senate and Assembly budget subcommittees' hearings, during which staff members provided an overview of each MRMIB program, as well as information on the transition of subscribers in the state-administered PCIP to the federally-run PCIP. Other items discussed included MRMIB's May Revise caseload updates, as well as the transfer to DHCS of AIM-linked infants from above 250 up to 300 percent of the federal poverty level and the extension of the MCO tax.

These items were approved by both subcommittees. However, the elimination or sun-setting of MRMIB was not approved by the subcommittees.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

Other State Budget Issues

There were no Other State Budget Issues presented to the Board.

TRANSITION OF THE HEALTHY FAMILIES SUBSCRIBERS TO THE MEDI-CAL PROGRAM

Update on Staff Transition

Janette Casillas reported on Agenda Item 5.a, Update on Staff Transition. The Board and Ms. Casillas then welcomed René Mollow.

Ms. Casillas indicated that she reported the transition of 20 HFP staff positions, including 10 that were filled, at the last Board meeting. Those 20 positions will be used to help DHCS with activities associated with oversight, monitoring and reporting of transition activities to the Centers for Medicare and Medicaid Services. For its second staff request, DHCS is currently reassessing its organization needs for additional staff and the type of experience needed.

Update on Transitioned Children to the Medi-Cal Program

Ms. Casillas reported on Agenda Item 5.b, Update on Transitioned Children to the Medi-Cal Program. On May 1, a total of 59,412 HFP children who were in Phase 1C transitioned to Medi-Cal. They were in Health Net in Los Angeles and San Diego counties. This component of the transition was delayed to provide subscribers with more time to select a new primary care physician. An additional 9,550 children were disenrolled for various reasons, including non-payment, per the member's request or ineligibility. For those children still in the program, HFP continues to conduct the annual eligibility review (AER). Ms. Casillas said it was sad that, at this time, only 154,069 children remained in HFP.

Call Center Report

Ms. Casillas reported on Agenda Item 5.c, the Call Center Report. She said calls are declining as enrollment in HFP declines.

The Call Center Report can be located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_5.c_HFP_Call_Center_Report_5-20-13.pdf

Transition versus Disenrollment Statistics

Ms. Casillas said Agenda Item 5.d, the Transition versus Disenrollment Statistics chart, was covered in her previous remarks to the Board.

The Transition versus Disenrollment Statistics chart is found here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_5.d_Transition_vs._Disenrollment_Statistics.pdf

Updated Schedule of Subscriber Notices

Ms. Casillas reported on Agenda Item 5.e, the Updated Schedule of Subscriber Notices. She pointed out that DHCS sent the 90-day notice to subscribers in Phase 3, which is the next group of children to transition, on May 1. This group will also receive an additional letter between now and their transition advising them to pick a new health plan in the Medi-Cal program. This will be done in advance of the transition so subscribers can move into a Medi-Cal plan upon transition.

The Phase 4 transition, which is the last group, is comprised of approximately 45,000 children who were originally expected to move out of an HFP managed care plan and into Medi-Cal's fee-for-service delivery system. However, with Medicaid's expansion and statewide managed care contracts, it is anticipated that these children actually will move into Medi-Cal managed care plans upon their transition. She said it was likely that some or many of these children will change plans, while some or many will be able to stay in their current plans. This is due to the fact that DHCS is contracting with Anthem Blue Cross, which is also an HFP contractor. To the extent that families want to stay with Anthem, they will now have that opportunity, which is good news for subscribers.

For Phase 4, Medi-Cal will send out a 90-day notice on June 1, and, shortly after that, a notice will be sent discussing new plans available through Medi-Cal.

The Updated Schedule of Subscriber Notices can be found here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_5e_5-29-13_Mtg.pdf

Department of Health Care Services' March 2013 Survey of Phase 1A Transitioned Children

Ms. Casillas reported on Agenda Item 5.f, the DHCS March 2013 Survey of Phase 1A Transitioned Children. This report was mentioned at the last Board meeting, after which Board members requested that MRMIB staff locate the report and present it to the Board.

Ms. Mollow said that the report is based on a survey of former HFP families who had transitioned to Medi-Cal as part of Phase 1A. The goal of the survey was to reach out to beneficiaries approximately 45 days after transition regarding their experience and the services they received. More than 10,000 phone calls were made to solicit feedback from individuals. Responses were obtained from approximately 349 individuals.

Most respondents did not identify problems seeking services through their Medi-Cal providers. For those who had scheduled services with a dentist, a majority reported having a better or the same experience as they had in HFP. About 37 percent indicated that they had a better experience in making or keeping an appointment with a dentist after the transition.

For mental health services, 60 percent of respondents indicated they had similar or the same experience in accessing mental health services under the Medi-Cal program. For alcohol and drug treatment services, respondents reported better experiences in Medi-Cal than in HFP.

Ms. Mollow noted that the survey response was low and DHCS has not seen a huge volume of individuals accessing the alcohol and drug treatment services. DHCS continues to monitor access to Medi-Cal mental health services.

Ms. Mollow mentioned that DHCS has a summary chart concerning survey respondents' access to providers. Ms. Mollow said that, in general, people indicated a positive experience with the transition and services. She said about 63 percent of respondents said they were very satisfied with their overall transition experience.

Ms. Mollow noted a lesson learned concerning the timing of phone calls. Most calls were made during the day, so DHCS has made efforts to change the time of the day in which calls are made and is trying to better tailor the questions.

Ms. Mollow also indicated that the goal was to make the calls less than 30 minutes. Ms. Mollow said she would provide the Board with the actual time the survey took and the time respondents were on the phone.

DHCS will conduct surveys for each phase of the transition. DHCS has not determined whether transitioned beneficiaries will be surveyed again after the transition is complete. However, Ms. Mollow said she is aware that such a survey would be of interest to people and DHCS will take it under consideration.

Mr. Figueroa asked whether these surveys will be released over time. Ms. Mollow said they would. Mr. Figueroa asked whether the Phase 1A group was the easiest to transition in terms of plan match between HFP and Medi-Cal. Ms. Mollow said that this was correct.

Mr. Figueroa asked whether the Phase 1B survey would be released two or three months after the transfer. Ms. Mollow said the Phase 1B survey was completed and results are being formatted for accessibility before posted to the DHCS website.

Chairman Allenby asked if there were any other questions or comments from the Board.

Ellen Wu asked whether an interpreter was used in making the survey calls to respondents who do not speak English. Ms. Mollow said she did not know and would find out. Ms. Wu said she would also like to know the language breakdown of the calls. She said that, with the small sample size of 349, it would be helpful to have this information since most HFP subscribers do not identify English as their primary language.

Ms. Wu also asked whether there was a plan to conduct utilization reports of the transitioned subscribers and possibly compare them to information regarding existing Medi-Cal beneficiaries or information from previous HFP utilization reports. She asked Ms. Mollow whether Medi-Cal had utilization or encounter data on the transitioned population.

Ms. Mollow said Medi-Cal has encounter data but indicated that she did not know whether it is identified by health service type, such as mental health or dental services. She said DHCS reports Medi-Cal dental service utilization. She said she would look into the extent to which utilization data could be provided and noted that Medi-Cal does track individuals by aid code.

Ms. Casillas said the Legislature may also have addressed the HEDIS (Healthcare Effectiveness Data and Information Set) data. HFP monitors different measures and there is some overlap. It was her understanding that DHCS is to adopt all the HEDIS measures used by MRMIB for consistency, in addition to measures DHCS already uses. Ms. Mollow said that this was correct, and that dental and managed care reporting will begin next year.

Chairman Allenby asked if there were any questions or comments from the audience. There were none.

The Department of Health Care Services' March 2013 Survey of Phase 1A Transitioned Children is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_5.f_DHCS_March_2013_Survey_of_Phase_1A_Transitioned_Children.pdf

Questions and Answers with Department of Health Care Services Representative

Beth Abbott of Health Access said that it was important for notices sent to HFP subscribers for Phase 4 to include a clear, plain language discussion of the

continuity of care provision in law. She said that it is anticipated this may be needed more frequently in Phase 4 than in previous phases because of the misalignment between HFP and Medi-Cal contracted plans for those subscribers.

Chairman Allenby asked whether Ms. Abbott was given the opportunity to review the Phase 4 subscriber notice. Ms. Abbott said that she had, but that the notice does not contain language about this provision.

Other HFP Transition Issues

No Other HFP Transition Issues were reported to the Board.

EXTERNAL AFFAIRS UPDATE

Jeanie Esajian reported on Agenda Item 6, the External Affairs Update. The last 30 days were busier than previous reporting periods and included several media inquiries. Those were from *California Healthline*, *The Sacramento Business Journal, PBS* and *The Associated Press.* These inquiries were on the topics of improved data utilization in the HFP-to-Medi-Cal transition, AIM program use, the transition of California PCIP subscribers to the federal PCIP and proposed legislation affecting California Public Records Act exemptions.

Ms. Esajian indicated that MRMIB issued a news release on May 20, and that the release was included in the Board's packet, along with representative samples of news items on which MRMIB received inquiries. Those included the PCIP subscriber transition, autism and dental services for HFP subscribers transitioning to Medi-Cal, and the impact of HFP transition coupled with impacts of healthcare reform on one California county.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The document on the External Affairs Update is located at: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item%206_052913_Meeting.pdf

STATE LEGISLATION

Jordan Espey reported on Agenda Item 7, State Legislation. Six bills were added to the report and six bills were amended since the last Board meeting. These bills are clearly identified in the report.

Since the last Board meeting, the Governor signed two Special Session bills, ABX1-2 and SBX1-2, into law; the bills addressed individual and small group market reform. SB 28, one of the bills amended since the last report, currently requires MRMIB to provide contact information for MRMIP and PCIP subscribers to Covered California. Some amendments may be made.

Similarly, SB 800 requires DHCS to provide Covered California with contact information for HFP parents not currently enrolled in Medi-Cal. Since the

Legislative Report was written, AB 617, which addresses the appeals process for Covered California and subsidy programs, including HFP and AIM, passed the Assembly and now moves to the Senate. Friday is the last day for bills to pass out of their house of origin.

Chairman Allenby noted that bills which do not pass out of their house of origin will become two-year bills.

Mr. Figueroa asked whether some of the bills in the State Legislation report may already have moved off the suspense file because of the time gap between when the report is written and the Board meeting. Mr. Espey said that this was correct and that movement would be reflected in next month's State Legislation report.

Chairman Allenby asked if there were any other questions from the Board or the audience. There were none.

The document for State Legislation is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_7_Legislative_Summary_5-29-2013.pdf

PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) UPDATE

Transition of California PCIP Subscribers to Federally-Administered PCIP

Ms. Casillas reported on Agenda Item 8.a, the Transition of California PCIP Subscribers to the Federally-Administered PCIP. As of the last Board meeting, MRMIB staff was working to advise CMS on the amount of funding that would be needed for the duration of the program and was working toward developing fiscals for to resume a quarterly contract cycle for the remainder of the year.

Ms. Casillas stated that things changed quickly at the end of April, as CMS looked at program fiscals nationally. The result was a surprising draft contract from CMS containing a provision that capped California's allocation at $290 million and eliminated current language holding California harmless for any expenditures. This latter provision is required because California law does not allow state funds to be used for this program and is a method of complying with state law.

Ms. Casillas explained that, based on analysis by MRMIB staff, the PCIP third party administrator HealthNow and MRMIB's external actuary PricewaterhouseCoopers, the $290 million amount fell approximately $38 million short of projected need. MRMIB countered with this additional need, as well as the need to maintain the hold harmless contract language. Ms. Casillas said it appeared that the latter provision was a bigger issue for CMS than the request for increased funding. Mr. Allenby indicated that California had no choice concerning the need for this provision. Ms. Casillas indicated her understanding that CMS also believed it had no choice, given their attempt to stretch limited dollars nationally. Ms. Casillas indicated that, in early June CMS notified MRMIB that CMS would not offer a contract through December 2013. Instead, CMS directed that California PCIP subscribers be transitioned to the federally-administered program, effective July 1.

CMS notified MRMIB approximately 45 days in advance of the transition date, and this has triggered a great deal of activity.

Ms. Casillas indicated that agenda Item 8.a.i is a letter that went to Secretary Sebelius from NASCHIP, the National Association of State Comprehensive Health Insurance Plans. NASCHIP's concern was the timing, especially the short notice, and the states' inability to try to develop other alternatives within the time frames.

She explained that agenda Item 8.a.ii provides the CMS response to many states' concerns and to the fiscal challenges and the need to make many adjustments to make the dollars stretch.

Chairman Allenby asked Ms. Casillas to describe the activities CMS is undertaking to make the federal dollars stretch. Ms. Casillas said that, in addition to shifting many of the state-administered programs to the federally-administered program, CMS also proposed, through regulations, a reduction in provider reimbursement in the federally-administered PCIP to Medicare reimbursement levels. This would be effective July 1, and essentially creates a wide-open network to include any provider that accepts the Medicare reimbursement level. This means that California subscribers will transition from their current network, provided through HealthNow, to a network that is broadly open to the extent that the provider will accept Medicare. Another aspect of this rule is a provision that holds PCIP subscribers harmless from balance billing, so providers cannot bill the patient for the difference. While the balance billing provision is good for subscribers, it will be challenging for them to navigate this change in the network.

Agenda Item 8.a.iii is another article that addresses the number of states that will transition to the federally-run PCIP. There were originally 27 state-administered programs. Now there will be about 10, because these states chose to take on the financial risk.

Chairman Allenby asked whether these states had financial liability prior to PCIP. Ms. Casillas said that this was correct and that CMS has publicly disclosed the names of the 10 states that will continue to operate PCIPs.

Agenda 8.a.iv is a chart provided by CMS. This is one of the few times that CMS has publicly released PCIP expenditure data. California has the largest program and the largest uninsured population, as well as the largest number of claims. California has the largest PCIP allocation of any state. The original allocation to California was $761 million for the duration of the program. However, even with the early transition, a review of all PCIP claims encumbered in California, as well as transition costs and the claims run-out period, indicates that the state has spent more than $761 million.

Chairman Allenby pointed out that California has received adjustments in its allocation subsequent to the original announcement of the allocation. Ms. Casillas said that this was correct.

Ms. Casillas noted that agenda Item 8.a.v is an article on the states that are continuing to operate PCIPs and those that will transition their programs to the federal program.

Agenda Item 8.a.vi is the press release sent out by MRMIB to inform PCIP subscribers and the public about the transition.

Agenda Item 8.a.vii is a comparison chart of the premiums for California PCIP and the federally-administered PCIP. Some California PCIP subscribers will have an increase in premiums and some will have a decrease when the move to the federally-administered PCIP occurs. A point-in-time assessment of current subscribers and their ages found that 58 percent will have increases and 41 percent will have decreases in their premiums. Premiums will be set in the federal program based on the subscriber's age at the time of transition and will remain at the same rate until the end of the year. In other words, a subscriber observing a birthday between July 1 and December 31 will not receive a premium increase.

Agenda Item 8.a.viii, is the benefits comparison between the California-administered PCIP and the federally-administered PCIP. This Agenda Item was presented to the Board in February. The attached cover sheet provides new information from CMS regarding cost-sharing for deductibles. The federally-administered PCIP has different cost-sharing from the California-administered PCIP. Because the transition is mid-way through the benefit year, CMS has reduced the annual medical deductible by half, so instead of being $2,000, it is $1,000. The pharmacy deductible is the same as the California-administered PCIP and the out-of-pocket maximum also will be reduced by half.

Chairman Allenby pointed out that California PCIP subscribers who already met their annual deductible will have to pay the deductible for the federally-administered PCIP.

Ms. Casillas said that this was correct. She said a staff analysis conducted in April found that 26 percent of California PCIP subscribers had already reached their medical deductible and would have expected to receive services for the remainder of the year without payment of additional deductibles for medical services. Additionally, 14 percent of California PCIP subscribers had reached their out-of-pocket maximum by April.

However, on a positive note, these subscribers will continue to have healthcare coverage, which is something that they would not otherwise have, until January. Chairman Allenby pointed out that, to be eligible to enroll in PCIP, these individuals also did not have health coverage for at least six months prior to their enrollment.

Agenda Item 8.a.ix is a letter sent [May 24] by MRMIB to subscribers enrolled in the California-administered PCIP. The letter was sent in English and Spanish and notified subscribers of the forthcoming transition. This letter was largely based on a template provided by CMS and was reviewed and approved by CMS in advance of mailing.

Agenda Item 8.a.x is a letter that CMS will send to California PCIP subscribers on or about June 10, to notify them of the transition. CMS also will send subscribers a benefit summary for the federal program, information about premium costs, their new ID cards, and information on where to send premium payments and where to call with questions. California-administered PCIP subscribers also will receive a transition-of-care document from CMS. Ms. Casillas indicated that this will be shared with the Board as soon as a copy is obtained.

Ms. Casillas stated that MRMIB staff and contractors continue to have weekly calls with CMS and its contractors to share information and coordinate call center scripts. Data transmission testing has begun between MRMIB eligibility contractors and CMS contractors. The California program enrollment file will be sent to CMS this Friday so CMS can prepare to upload data. Individual updates will be sent to CMS as they occur.

MRMIB continues to have calls on coordination of care. The California program will facilitate a soft hand-off of California subscribers receiving care management so the federally-administered program will know who they are, what conditions they have and what their medical needs are. This process will also coordinate prior authorizations that were already approved where services will continue after July 1 for either pharmacy or medical services.

Once the call center scripts are approved for Health Now, the third party administrator, and Maximus, the administrative vendor, the scripts will be shared with the Department of Managed Health Care for use by its call center.

Ms. Casillas explained that CMS officials have stated that they appreciate the information MRMIB staff and contractors have shared with them so far, but do not want the California program to get too detailed in answering subscriber questions regarding the federal PCIP benefits or the federal process. California will provide access to information by offering the toll free number and website for the federally-administered PCIP.

Ms. Casillas said that MRMIB staff has mixed emotions about the PCIP transition. Staff members did a great job, provided a great service to California subscribers and were disappointed at not being able to see the program through to December 31. However, MRMIB staff are doing all they can to ensure that these subscribers continue to have coverage through year's end. She noted that CMS would be the entity coordinating with state exchanges to send PCIP subscribers notices about the exchanges and the individual market.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The documents on the Transition of California PCIP Subscribers to Federally-Administered PCIP are all located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_item8aMay29_13.html

Enrollment Report

Ernesto Sanchez reported on Agenda Item 8.b, the PCIP Enrollment Report. In April, new applicants were no longer being enrolled in PCIP for applications received after March 2. A total of 87 individuals were enrolled during April, from applications received prior to March 3, bringing total enrollment to 16,847. No major shifts in demographics were reported and all applications received prior to March 3 have been processed.

Since California has a joint application for PCIP and the Major Risk Medical Insurance Program, new applications continue to be received that specify a preference for PCIP or do not specify a preference. This accounts for approximately 32 percent of applications received. Staff members have reached out to those individuals, with the result that 38 percent of them opted to have their application forwarded to MRMIP, 28 percent have declined and staff members have been unable to reach the remaining 34 percent. The applications of this latter group will be automatically forwarded to MRMIP.

Mr. Sanchez indicated that he had provided the Board with a chart showing national PCIP enrollment nationwide as of March 31.

Chairman Allenby asked if there were any questions or comments from the Board or the audience.

Richard Figueroa asked whether the PCIP and MRMIP application would be separated and an application created specifically for MRMIP since the May Revise did not propose elimination of MRMIP. Mr. Sanchez said that the change would be handled with an errata sheet, to be included with the joint application. He noted that PCIP applications could continue to be received in the portability category.

Mr. Sanchez said that numerous efforts are underway to make these changes known, including updates to the MRMIB website, subscriber notifications and public service announcements on the toll-free phone line. He said that enrollment entities and agents and brokers also were notified of the program changes.

Chairman Allenby asked if there were any additional questions or comments. There were none.

The PCIP Enrollment Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_8.b_PCIP_Enrollment_Report.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 8.c, the PCIP Administrative Vendor Performance Report. The administrative vendor met all performance standards for processing applications, eligibility determinations and appeals and toll-free line standards, as well as all requirements for quality and accuracy standards. Currently, no benefit appeals are pending.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The PCIP Administrative Vendor Performance Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_8.c_PCIP_Adm_Vendor_Board_Report_April_2013.pdf

Third Party Administrator Performance Report

Ellen Badley presented Agenda Item 8.d, the PCIP Third Party Administrative Vendor Performance Report. The vendor met all standards for medical and pharmacy claims processing. However, two provider claims were not processed within 30 days due to pricing review by Stratos, the vendor that negotiates high-cost and out-of-network claims on MRMIB's behalf.

There were no healthcare service appeals and 13 complaints from subscribers were handled within the contract standards. All of these calls met the contracted call processing standards. In the area of provider technical support, all provider calls and appeals were handled within performance standards. Subscriber materials were distributed as required, and there were no requests for expedited review. Two standard reviews were received in April and there were no requests for administrative hearings.

Chairman Allenby asked if there were any questions or comments from the Board of the audience. There were none.

The PCIP Third Party Administrator Performance Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_item_8.d_Third_Party_Administrator_Performance_Report.pdf

Fact Sheet: Prescription Medications

Tony Jackson presented Agenda Item 8.e, the Prescription Drug Sheet Fact Sheet. As of March 2013, PCIP provided prescription drug coverage to nearly 20,000 Californians, with 87 percent receiving prescription drugs. The plan paid more than $49.9 million in pharmacy claims, which accounted for 9 percent of PCIP claims payments. Generic drugs accounted for 76 percent of the prescribed drugs and brand-name drugs accounted for 24 percent. In contrast, generic drugs accounted for 25 percent of pharmacy claims payments and brand-name drugs accounted for 75 percent of pharmacy claims payments.

Subscribers receiving prescription drugs paid an average of $337 in monthly premiums. Fifty-five percent of these subscribers were female and 45 percent were male. The average age of subscribers receiving prescription drugs was 46.

Top prescription drugs for subscribers aged 1 through 11 were medications to treat asthma, heart disease, and seizures. Top prescription drugs for subscribers aged 12 to 19 were medications to treat bipolar disorders, asthma, and diabetes and birth control medications. Top prescription drugs for subscribers aged 20 and older were medications to treat pain, diabetes and asthma.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The PCIP Fact Sheet: Prescription Medications document can be found here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_8e_May_29_2013.pdf

Utilization Reports

Ellen Badley presented Agenda Item 8.f, the PCIP Utilization Reports: the first quarter report for January through March 2013 and the inception-through-March 2013 report.

First quarter inpatient facility usage continued to take the largest share, at nearly 42 percent, followed by outpatient facility usage at nearly 30 percent, outpatient professional services at about 15 percent, inpatient professional services at about five percent and prescription drugs at about nine percent. There were 2,223 admissions, with an average length-of-stay of almost six days. The top diagnosis by plan payment was cancer, which is the leading cost driver for the program. Other top diagnoses were respiratory failure, end-stage renal disease, encounters for radiotherapy and diverticulitis.

The split between pharmacy claims for generic and brand name drugs changed slightly, with generic utilization and expenditures now a slightly higher percentage. Ms. Badley attributed this to the fact that some of the block-buster drugs are starting to come off brand and are available as generics.

She noted that 808 subscribers received the $50 wellness incentive, there were 57 callers to the nurse advice line, 13 disease management cases and 143 cases opened for care management.

Cancer continues to lead admissions, followed by pregnancy, childbirth and post-delivery costs.

In the inception-to-date report, Ms. Badley noted a big change in the number of calls to the advice nurse line. There were 57 calls in the first quarter of the year, as previously reported. However, in January, there was a change in the vendor that does care management, nurse advice and prior authorizations. For the inception-to-January period, the nurse advice line received 2,821 calls, raising questions whether that number was overstated in prior years.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. Chairman Allenby asked about the information provided for the states in which the federal government operates PCIP.

Ms. Casillas said that the federally-administered PCIP has a different pharmacy formulary from the California-administered PCIP. She said MRMIB has not done an in-house analysis of how the change in formulary would affect PCIP subscribers transitioning to the federal program. She said such an assessment

would likely be done by CMS, but that the change would likely impact the California subscribers.

Chairman Allenby asked if the federally-administered PCIP provides utilization reports.

Ms. Casillas said that CMS reported their nationwide program expenditures to date. She said the program fact sheets and utilization reports provided to the Board are all approved by CMS prior to being made public and that CMS has been clear that the data are theirs.

The PCIP Utilization Summary is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_item_8.f_Utilization_Reports.pdf

Other Program Updates

There were no Other Program Updates presented to the Board.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Larry Lucero presented Agenda Item 9.a, the MRMIP Enrollment Report. For the month of April, 326 new subscribers were enrolled with an effective date of May 1. This brings total current enrollment to 6,022, an increase of approximately 200 from the last reporting period but still below the program cap of 7,000. New enrollees to date increased by 324 from the last reporting period for Fiscal Year 2012-13. A total of 594 applications were received, an increase of 234 over last month, possibly due to the closure of PCIP and referrals of applicants to MRMIP.

There are currently 22 individuals on the wait list. These are persons who selected the MRMIP HMO option. There is no wait list for PPO subscribers.

[At this point in the proceedings, Chairman Allenby left the meeting and Mr. Figueroa chaired the meeting.]

There were no significant changes in plan or county distribution of subscribers and subscriber demographics were relatively unchanged.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The MRMIP Enrollment Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_9.a_MRMIP_Enrollment_Activity_from_June_2010-April_2013.pdf

Administrative Vendor Performance Report

Mr. Lucero reported on Agenda Item 9.b, the MRMIP Administrative Vendor Performance Report. The administrative vendor met or exceeded all performance standards for April 2013.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The MRMIP Administrative Vendor Performance Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_9.b_Administrative_Vendor_Report_April_2013.pdf

Semi-Annual Enrollment Estimate

Terresa Krum reported on Agenda Item 9.c, the MRMIP Semi-Annual Enrollment Estimate. Because of the closure of PCIP, MRMIP enrollment is increasing. Based on the number of applications forwarded to MRMIP in March and April, it is possible that the current enrollment cap is too low. However, because the PCIP closure was so recent, on March 3, there is not sufficient data upon which to base an actuarially sound recommendation. Therefore, staff recommends that the enrollment cap be increased to 7,500 effective June 1, 2013, and that the enrollment and cost trends be reviewed in August 2013. This will ensure that the program does not close prematurely to new enrollment because of the current low enrollment cap.

Mr. Figueroa asked whether official action by the Board was needed for this change. Ms. Krum said it was not the past practice.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

Draft Notice to Applicants: Coverage Options

Agenda Item 9.d, the Draft Notice to Applicants: Coverage Options was not presented to the Board.

2012-13 Third Quarter Financial Report

Amanda Evans presented Agenda Item 9.e, the 2012-13 Third Quarter Financial Report for the Major Risk Medical Insurance Fund, from which MRMIP is funded, for the quarter ending March 31, 2013.

The beginning balance on July 1, 2012, was $24.8 million. Anticipated revenues for the year are $32.2 million. Actual expenditures through March 31, 2013, were $5 million. Anticipated expenditures through the end of the year are $46.6 million, which would leave an estimated balance of $5.4 million.

Ms. Evans noted the footnotes explain that staff will be processing the payments now that there are fully executed contracts and the plans begin submitting subsidy

invoices. However, there will be a larger amount of expenditures paid in the last quarter, which will comprise the difference. The remaining fund balance of $5.4 million will be used for GIP [Guaranteed Issue Pilot Project] and MRMIP reconciliations during that time period as well.

Mr. Figueroa asked if there were any questions or comments from the Board or the audience. There were none.

The MRMIP 2012-13 Third Quarter Financial Report can be found at: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/agenda_item_9.e_MRMIP_3rd_qtr_financial_statment_2012-13.pdf

[Chairman Allenby returned to the dais and resumed chairing the meeting.]

Other Program Updates

Other Program Updates were not presented to the Board.

HEALTHCARE REFORM UNDER THE AFFORDABLE CARE ACT

Ms. Casillas presented Agenda Item 10, Healthcare Reform Under the Affordable Care Act. The California Health Benefit Exchange publicly released the plans with which it is contracting and received a great deal of media attention in the process. She said she would provide information and materials to the Board at its next meeting comparing the plans to be offered through Covered California with those offered through Board programs and Medicaid.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment Report

Mr. Sanchez presented Agenda Item 11.a, the HFP Enrollment Report. The HFP Enrollment Report shows that, as of April 30, there were 154,000 subscribers, down from 223,000 prior to the last transition phase. There has been no major change in subscriber ethnicity, gender or demographics in the top five counties.

The report provided enrollment by health, dental and vision plans, as well as disenrollment statistics for the last three months. Annual eligibility review (AER) disenrollments due to the 1931(b) and CalWORKS screening implemented last December 31 has increased.

Chairman Allenby asked if there were any questions or comments from the board or the audience. There were none.

The HFP Enrollment Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_11.a_HFP_Enrollment_Report_for_April_2013.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 11.b, the HFP Administrative Vendor Performance Report. The administrative vendor met all performance standards for processing, program reviews and appeals, data transmissions and toll-free line standards, as well as performance standards for quality and accuracy performance.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The HFP Administrative Vendor Performance Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_11.b_HFP_Administrative_Vendor_Report_April_2013.pdf

Appointment of HFP Advisory Panel Members

Ernesto Sanchez reported on Agenda Item 11.c, the Appointment of HFP Advisory Panel Members. He indicated that staff put forth four vacancies but received a response for only one. Staff will go forward with the other vacancies and bring them back to the Board at a future time. Chairman Allenby asked for a motion to approve the appointment of Dr. Paul Phinney to the HFP Advisory Panel. The motion was moved, seconded and unanimously approved.

Ms. Wu said that it seemed people were not applying for appointment to the Panel. Ms. Casillas said that this was correct. Ms. Wu asked whether the vacancies would remain. Ms. Casillas said panel vacancies are posted to the MRMIB website, incumbent Panel members are notified of vacancies in hopes they may know of someone who would be meet Panel position criteria, and letters have been sent out in the past to various groups and to various localities to recruit members. MRMIB staff will do everything possible to fill the vacancies before the Panel is transitioned to DHCS.

Ms. Casillas said MRMIB staff will assist Ms. Mollow and DHCS in transitioning the Panel to DHCS in January and will assist in developing meeting agendas and training DHCS staff during 2013. She asked the Board and audience for referrals to fill Panel vacancies.

Ms. Wu noted that there are not many advisory committees within DHCS, that the Panel serves a critical role and that its specific membership is written into statute. She encouraged everyone to work to fill Panel seats with people who will hold DHCS accountable for making sure that HFP children are getting the services they need.

Ms. Casillas said the goal is to fill the vacant Advisory Panel positions prior to the transition to DHCS. The Panel is currently meeting on a quarterly basis and all meetings are in Sacramento. In the past, meetings were held monthly and in various parts of the state. However, budget constraints and the program maturation led to changes in the meeting pattern. Monthly meetings and various locations could be resumed.

Mr. Campana said the Panel has already begun discussing meeting frequency and locations with Ms. Mollow. He said meeting only quarterly was detrimental. If a member misses one or two meetings a year, there is no real significance in being there. He said a discussion about defining the role of the Advisory Panel was on the agenda for the next meeting, scheduled for the day after the Board meeting. He said the Panel should be significant within DHCS. He expressed the hope for a meeting every two months, especially during the transition. He asked the audience for its help in finding members to fill Advisory Panel vacancies before the end of the calendar year.

Chairman Allenby asked if there were any questions or comments of the Board or the audience. There were none.

The Appointment of HFP Advisory Panel Members document is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_11.c_Appointment_of_HFP_Advisory_Panel_Members.pdf

2012 Survey of Teen Health Care Experience

Ms. Badley reminded the Board that the 2012 Survey of Teen Health Care Experience was presented at the Board's April meeting. However, it was added to the Board's packet shortly before that meeting, so the Board did not have ample time to review the document. She said the report was on the agenda again to allow for Board questions and discussion.

Mr. Figueroa noted the response rate of the survey as compared to the response rate of the Phase 1A HFP-to-Medi-Cal transitioned subscribers' survey. Ms. Badley said the teen survey respondents were provided with a five dollar Target gift card as an incentive to participate. Mr. Figueroa said that was enough to obtain a 30 percent response. Chairman Allenby said the response rate was very good. Mr. Figueroa agreed, and said the response rate was statistically significant.

Ms. Casillas said that, in addition to providing the gift card incentive, MRMIB hired a contractor that has the ability to make phone calls when people are home, in the evenings or on weekends, in several languages, using the phone or mail. She asked whether DHCS will conduct a Medi-Cal CAHPS survey (Consumer Assessment of Healthcare Providers and Systems) based on the trailer bill providing for transition of HFP Children to Medi-Cal and whether it will be done after the transition is completed, not just during Phase 1A or 1B.

Mr. Figueroa asked whether there was a similar requirement that DHCS conduct the YAHCS survey (Young Adult Health Care Survey). Ms. Casillas said she didn't believe that was required. She noted that CAHPS includes all consumers, but MRMIB used both surveys to gain a better understanding of young adult subscribers.

Ms. Badley added that not only was the Teen Survey conducted by phone and through the mail, but subjects were provided with an online option as well. Mr. Figueroa asked whether staff had statistics on respondent use of the various

response modes. Ms. Badley said she would follow-up with the survey contractor to obtain the information.

Ms. Casillas said the current Survey, which will be the final one, was in the field and that staff will include a breakdown of responses by the various modes in the closing report to the Board. Mr. Figueroa said the information may be of value to DHCS for its future use. Ms. Casillas said staff is trying to include “lessons learned” or recommendations in its final reports for purposes of sharing with other states, DHCS and other interested parties.

Chairman Allenby asked if there were any other questions or comments from the Board or the audience.

Jack Campana said he had spent more time reviewing the survey and was pleased with the 30 percent response rate. He considered the responses to the question about what teens discuss with their doctors disturbing. He said it was apparently easy for doctors to talk to teens about physical activity, exercise or weight. However, when the survey asked questions about emotions, moods, suicide, sexual orientation or sexually transmitted diseases, there was a significant drop.

He recounted his past work with surveys and noted that the Centers for Disease control required at least a 65 percent return to be deemed statistically significant. He recalled a specific CDC question asking teens in high school whether there was a period of time of three weeks or more in the last year during which the teen felt so sad or depressed that this actually changed normal activities. He said the response for that question was approximately one-third, which was significant. In contrast, the question in the Teen Survey regarding emotions and suicide had a 19 percent and seven percent response, respectively. Mr. Campana said that, while it was easier for doctors to talk to teens about exercise, emotions are important and should be discussed.

The HFP 2012 Survey of Teen Health Care Experience is located at: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_item_11.d_HFP_2012_Teen_Health_Care_Experience_Survey_Report.pdf

2011-12 Out of Pocket Expenditures Report

Alexa Malik presented Agenda Item 11.e, the 2011-12 Out-of-Pocket Expenditures Report. Federal law limits member cost sharing, including monthly premiums and co-payments, to no more than five percent of the subscriber’s annual household income. HFP has assured compliance with these requirements by limiting the total amount of co-payments incurred for health services per family to no more than $250 per benefit year, regardless of family size.

Each plan reports annually to MRMIB on the number of families that incurred at least $250 in co-payments in each benefit year. The data collected is used to identify which families reached the co-payment maximum and then determine whether the family exceeded the five percent federal limit.

For this benefit year, only one family exceeded five percent of their annual income and that family was reimbursed for the amount the family paid over $250. The number of families reaching the co-payment maximum continues to increase, especially during the last three years, largely because of the November 2009 co-payment and premium increases.

Even with this increase, families reaching the co-payment maximum account for less than 1 percent of HFP subscriber families overall. The report also showed a significant difference in the rates reported by those families with Asian language preferences. MRMIB staff compared this data to HEDIS (Healthcare Effectiveness Data and Information Set) report data and found that Asian language speaking families also showed lower utilization for certain HEDIS measures.

MRMIB contracts require HFP plans to notify subscriber families of the annual co-payment maximum. MRMIB provides this information in the welcome letter and HFP Handbook, and on the HFP website. HFP health plans are required to include this information in the Evidence of Coverage or Certificate of Insurance document, and must inform subscribers twice annually of the $250 maximum.

Despite numerous efforts by MRMIB through contracting plans, the percentage of subscribers who notify their health plans when they reach the co-payment maximum is very low, 16 percent. Because this is the final Out-of-Pocket Expenditures Report, staff included a "lessons learned" section. Because of the significantly low percentage of families notifying their health plan when they reach their co-payment maximum, MRMIB recommends further research to determine whether other strategies should be employed to conduct outreach to families on this issue.

Chairman Allenby asked if there were any questions or comments from the Board or the audience.

Ms. Wu said she appreciated the analysis of families by language and the cross-reference to HEDIS. She indicated that this is the kind of analysis and comparison that is valuable and helpful, and that it provides a fuller picture from which she hopes DHCS will learn.

The 2011-12 Out of Pocket Expenditures Report can be found here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_11e_2011-12_OOP_Expenses_Report.pdf

2011-12 California Children's Services Report

Ms. Badley presented Agenda Item 11.f, the 2011-12 California Children's Services Report. She acknowledged Juanita Vaca, who prepared the report, which offers a summary of health and dental services provided to HFP children by CCS during the 2011-12 benefit year.

Each benefit year, HFP-contracted plans are required to report to MRMIB on the number of children they refer to the counties for assessment and possible treatment of a serious or chronic condition. In addition, MRMIB obtains information

from DHCS on referrals to the county CCS program, the number of active cases, the predominant conditions and the cost of providing care to HFP children receiving services from CCS. MRMIB uses the information received from the plans and DHCS to monitor trends in costs and services, and to ensure that HFP children are receiving medically necessary care.

In 2011-12, the plans referred 19,290 children, or approximately 2 percent of total HFP enrollment, to CCS. This was an increase from the previous benefit year, when more than 16,000 children were referred. Of those referred children, CCS accepted 82 percent. Four health plans referred more than 3 percent of their HFP enrolled children, and two plans – Inland Empire and Ventura County –referred 10 and five percent of their HFP enrollment, respectively. At the end of the benefit year, there were 26,482 active cases, a slight decrease from the prior year. Expenditures decreased by 38 percent, from $215 million to $132 million. However, while there was a spike in costs in 2010-11, this dropped in 2011-12 and resumed a pattern similar to 2009-10 expenditures.

MRMIB staff has spoken with DHCS to try to understand what accounted for that spike in expenditures. However, with no clear understanding, it could be the lag time in claims from date of service to payment, possibly into a subsequent benefit year.

The average cost per case also decreased, from $8,707 in the prior year to $5,666, which was also comparable to 2009-10 costs. The average cost for an HFP child is still significantly lower than for a Medi-Cal child, who has an average cost of nearly $14,000.

Chairman Allenby asked whether staff thought costs would rise with the transition of HFP children to Medi-Cal.

Ms. Badley said that HFP-contracted health plans are required to provide services for serious chronic conditions if the family does not want services from CCS or if CCS does not authorize and provide services. If these are covered benefits under HFP, plans must provide those services.

Ms. Casillas said she would expect to see CCS costs for former HFP subscribers to increase and be more comparable to those of the Medi-Cal Program because it is a clear carve-out in Medi-Cal and the plans are not required to backfill until CCS is able to provide the service. It is not a benefit that the Medi-Cal plans are obligated to provide. She said local CCS programs working to manage resources that were limited would prioritize services to the Medi-Cal population because they knew that HFP children would still receive medically necessary services through their plans. That will not be true once HFP children move to Medi-Cal.

Chairman Allenby said that this was a hidden cost. Ms. Casillas concurred and said county mental health departments have raised this issue and believe they will have huge non-reimbursed costs in caring for the HFP children. Local CCS programs will see a huge shift and demand, which Chairman Allenby characterized as another hidden cost. Mr. Figueroa said it was actually an unaccounted-for cost.

Chairman Allenby asked if there were any other questions or comments from the Board or the audience.

Mr. Figueroa said he was struck by the variability in number of referrals made by plans. For example, the Inland Empire Health Plan referred nearly 10 percent of its HFP enrollment while other plans referred no children. He wondered whether activities such as screening, use of a screening tool or instrument, or some other factor accounted for this difference.

Ms. Casillas said staff believes some plans are more observant about not providing services for which they are not reimbursed. While the plans are paid on a capitated basis and are required to make CCS referrals, they are also required to provide the services until CCS begins providing services to the subscriber. On the other hand, Kaiser tends not to refer and instead provides subscribers with comprehensive services from beginning to end. It is not part of Kaiser's philosophy to carve out these services.

Ms. Casillas said there are other plans that have not established an infrastructure to identify and refer these children. Plans are more conscious of this in the Medicaid world because the provider's rate is lower and plans are not inclined to provide services for which they are not being reimbursed.

Ms. Badley concluded by saying this was the last time the California Children's Services report would be presented to the Board because of the transition of HFP to Medi-Cal.

The 2011-12 California Children's Services Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_item_11.f_CCS_REPORT_2011-2012.pdf

2012 Grievance Report

Ms. Malik presented Agenda Item 11.g, the 2012 Grievance Report. Every year MRMIB requires the HFP health, dental and vision plans to report on grievances filed by Healthy Families subscribers. This report represents grievances reported for calendar year 2012. For the first time, the report also includes the total number of complaints that MRMIB received directly from subscribers.

In all, 30 HFP health, dental and vision plans reported 3,324 grievances from nearly 900,000 subscribers in 2012. The health plans represent 84 percent of all grievances reported. The overall grievance rate decreased in the last four years from a rate of 48 per 10,000 subscribers to 38. Additionally, claims and quality of care continue to be the leading types of grievances filed each year.

The demographic analysis shows that whites, who account for only nine percent of HFP enrollment, had the highest grievance rate. Data also show that English speakers filed grievances at a higher rate than those who spoke other languages. Both of these trends have been consistent throughout the past four years.

This year's report also included the total number of plan grievances received by MRMIB directly from subscribers. HFP subscribers submitted 393 complaints directly to MRMIB. Eighty-seven of these grievances were also received by the plan. The demographic breakdown for the complaints received by MRMIB shows that, of subscribers who identified an ethnicity, Latinos filed the majority of the complaints. In contrast, when this data was compared with the data for grievances filed directly with the health plans, Latinos had one of the lower rates for filing grievances.

Ms. Malik said plans continued to make progress in addressing subscriber concerns, resulting in a decline in the number of grievances per 10,000 subscribers over the past years.

Chairman Allenby asked if there were any questions or comments from the Board or the audience.

Ms. Wu said she appreciated the report's breakdown by demographic characteristics. While there are differences, the differences are not as large as she would have expected, given the accessibility to some of the grievance processes.

The 2012 Grievance Report can be found here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_item_11.g_2012_Grievance_Report_with_changes_after_board_mtg.pdf

Other Program Updates

Other Program Updates were not presented to the Board.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Mr. Lucero reported on Agenda Item 12.a, the AIM Enrollment Report. During the month of April, 764 women enrolled into the AIM program, bringing current total enrollment to 6,080. This represents a decline in enrollment of approximately 90 subscribers from last month. There were no changes in subscriber demographics or enrollment distribution by county. The same 18 counties continue to account for more than 86 percent of all AIM enrollment, and subscriber distribution by plan also remains unchanged.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The AIM Enrollment Report is located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_12.a_AIM_Enrollment_Report_April_2013.pdf

Administrative Vendor Performance Report

Mr. Lucero reported on Agenda Item 12.b, the AIM Administrative Vendor Performance Report. The AIM administrative vendor met or exceeded all performance and quality accuracy standards for the reporting period.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The AIM Administrative Vendor Performance Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_Item_12.b_AIM_Administrative_Vendor_Report_April_2013.pdf

2012-13 Third Quarter Financial Report

Ms. Evans reported on Agenda Item 12.c, the 2012-13 Third Quarter Financial Report for the Perinatal Insurance Fund used for the AIM program; the report addressed the quarter ending March 31, 2013. The beginning balance on July 1, 2012 was $18.4 million. Anticipated revenue for the year was $47.8 million. Actual expenditures, as of March 2013, were $41.9 million.

Ms. Evans noted that in the previous quarter, MRMIB reported $245,000 in payments to the administrative vendor. However, payments from the Perinatal Fund actually totaled $99,000. The difference was that all costs were reported, not just costs incurred in the Perinatal Fund. This quarter, payments to the administrative vendor were $152,000, which is back in line for the third quarter.

Anticipated expenditures for the rest of the year are $16 million, leaving a fund balance of $8.3 million.

Chairman Allenby asked if there were any questions or comments from the Board or the audience. There were none.

The AIM 2012-13 Third Quarter Financial Report is located here: http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052913/Agenda_item_12.c_2012-13_Third_Quarter_Financial_Report.pdf

Other Program Updates

No Other Program Updates were presented to the Board.

The meeting was adjourned at 12:44 p.m.